Kentucky Local Health Department
Child Fatality Review Team Meeting Report Form

Health Department _____ County _____ Phone _____
Person Completing Report _____ Coroner/Deputy _____
Date of CFR Team Meeting _____

Agencies Represented (check all that apply):

- ☐ Coroner
- ☐ DCBS
- ☐ Fire Department
- ☐ Mental Health
- ☐ Law Enforcement
- ☐ Health Department
- ☐ EMS
- ☐ Physician
- ☐ Attorney
- ☐ Other _____
- ☐ Other _____

Case(s) Reviewed: New Case ☐ Update ☐ Is Review Complete: ☐ Yes ☐ No

Child's Name	Date of Death	Age of Child	Preliminary Manner/Cause of Death	Risk Factors and/or comments

Check all that apply:	Provided after death	Offered but not wanted	Needed but not available	Unknown	CFR Review led to referral
Grief Counseling	☐	☐	☐	☐	☐
Economic Support	☐	☐	☐	☐	☐
Funeral Arrangements	☐	☐	☐	☐	☐
Emergency Shelter	☐	☐	☐	☐	☐
Mental Health Services	☐	☐	☐	☐	☐
Foster Care	☐	☐	☐	☐	☐
Health Care	☐	☐	☐	☐	☐
Legal Services	☐	☐	☐	☐	☐
Family Planning	☐	☐	☐	☐	☐

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Family Planning	☐	☐	☐	☐	☐

Possible Risk Factors:

- Natural Death to Infants: Previous infant or fetal loss, inadequate prenatal care, poverty, substance/alcohol abuse, tobacco use, exposure to environmental hazards, medical neglect, unintended pregnancy, etc.
- Asthma: lack of treatment, African-American and low income children, increased exposure to allergens and infections, exposure to environmental hazards, non-compliance with prescribed treatment, and failure of parents to recognize seriousness of attacks
- Sudden Infant Death Syndrome (SIDS): infants sleeping on their stomachs, loose bedding, maternal smoking during pregnancy, second-hand smoke exposure, overheating, prematurity or low birth weight, faulty crib or bed design, co-sleeping, quality of supervision at time of death
- Suffocation: place where child was sleeping or playing, position of child when found, type of bedding and other objects near the child, faulty bed/crib design, co-sleeping, quality of supervision at time of death
- Fire and Burns: lack of working smoke alarms in the home, quality of supervision at time of death, drug/ alcohol abuse by supervising adults, child's access to lighters/matches, falling asleep while smoking, leaving candles burning, lack of education about fire safety, lack of escape plan, use of alternate heating sources, code violations, timeliness of fire rescue response
- Drowning: lack of adequate adult supervision, drug/alcohol by supervising adult, access to pools, ability to swim flotation devise used appropriately
- Motor Vehicle Deaths: location of passenger, not using proper restraint systems/seat belts, not wearing safety equipment, unskilled drivers (ATV's, motor cycles, etc), riding in bed of truck, small children playing around vehicles, crossing streets unsupervised, exceeding speed limits, passenger with a new driver, riding with three or more passengers, driving between midnight and 6 am, alcohol use by driver/passengers, etc
- Suicide: long-term/serious depression, previous attempt, mood disorders/mental illness, substance abuse, childhood abuse, divorce/separation of parents, inappropriate access to firearms, lack of social support, family suicide, suicide of friend, bullying, sexuality issues, etc
- Homicide: access to firearms, poverty, crime, family violence, little/no adult supervision, early school failure, delinquency, gang/drug activity, early exposure to violence

Was the meeting effective: ☐ **Yes** ☐ **No**

Factors that prevented an effective review:	**Review meeting outcomes, check all that apply:**
☐ Confidentiality issues prevented full exchange of info ☐ HIPPA prevented access to/or exchange of info ☐ Inadequate investigation – not enough info for review ☐ Members did not bring adequate info to the meeting ☐ Necessary team members were absent ☐ Meeting was held too long after death ☐ Records or info were needed from another county ☐ records or info were needed from another state ☐ Team disagreement on circumstances	☐ Review led to additional investigation ☐ Review led to the delivery of services ☐ Review led to changes in agency policies or practices ☐ Review led to prevention initiatives being recommended: ☐ Locally ☐ Statewide Could the death have been prevented: ☐ No, probably not ☐ Yes, probably ☐ Not determined Did team members conduct any assessment of the risk factors and possible resources, services, programs, or initiatives related to the prevention of this type of death: ☐ No ☐ Yes-If yes, check all that apply: ☐ Literature review ☐ Presentation by experts ☐ Data collection/analysis ☐ Review programs ☐ Review services ☐ Review resources ☐ Contact existing groups ☐ Contact existing agencies

Additional Comments: _____

To effect this change, what specific recommendations and/or actions resulted from the review: ☐ **No Recommendations**

	Suggested Group/Agency	**Local or State**
Media Campaign		
School Program		
Community Safety Project		
Provider/Parent Education		
Public Forum		
New/Amended Policy/Law		
New Program/Services		
Enforcement of Law/ordinance		
Modify or Recall Consumer Product		
Modify a Public/Private Space		
Other		

Confidentiality and Child Fatality Review in Kentucky

The HIPPA Act does not prohibit sharing of confidential information between the coroner and team member agency representatives during a child death case review. According to C.F.R. 164.512(b), covered entities may use or disclose Protected Health Information (PHI) without authorization of the individual or the legal representative of the individual, if the uses and disclosures are for public health activities that are authorized by law to collect or receive the information for the purpose of preventing or controlling disease, injury or disability. Proceedings of a Child Fatality Review Team meeting are protected from discovery according to KRS 211.686.
HIPPA also requires, as does KRS 72.410, that any PHI disclosed among child fatality review (CFR) team members during a child death case review meeting, be maintained in confidentiality by those participating in the review process. A team member shall not share any disclosed information outside the meeting discussion unless authorized by law. Follow-up provision of family services or further investigation into the case may appropriately occur by CFR team agency representation protocol.

KRS 72.410

- Requires coroners, upon being notified of a child death under the age of 18 years, which meets the criteria for a coroner's case according to KRS 72.025, to contact the local Department for Community Based Services, law enforcement agencies with local jurisdiction and the local health department to determine the existence of relevant information concerning the case.
- Requires agencies to provide cooperation, assistance and information to the coroner upon his request.
- Requires maintenance of confidentiality of records disclosed.

KRS 211.686

- Authorizes coroners to establish local child fatality review teams and suggests membership and purpose.
- Protects proceedings, records opinions and deliberations of the local team as privileged and not subject to discovery or subpoena.

KRS 620.050

- Allows the Department for Community Based Services to disclose information to the coroner and local child fatality review team.